



# STATE OF NEW YORK MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		OFFICE OF EXAMINER		COUNTY		STATE	

BUREAU V. 1

JUN 3 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
05649 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

05596  
304

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>		c. LENGTH OF STAY IN life <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>at home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rhoda</u> Middle <u>Irene</u> Last <u>Baker</u>		4. DATE OF DEATH Month <u>May</u> Day <u>20</u> Year <u>19 57</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1875</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Sullivan-Franklin Co. Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob McCarty</u>		14. MOTHER'S MAIDEN NAME <u>Jane Hitchcock</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Paul L. Baker- Son</u>		Address <u>Hancock, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive cardio-vascular disease</u> <u>443X</u> DUE TO <u>myocardial heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> 19 p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-22-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Little Cove Methodist</u>		22d. LOCATION (City, town, or county) <u>Hancock</u> (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Brown Hancock</u>		24. REC'D BY REGISTRAR <u>  </u> 24. REGISTRAR'S SIGNATURE <u>  </u>	
ADDRESS <u>  </u>		DATE <u>5/20/57</u>	

RECEIVED  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
STATE OF NEW YORK

BUREAU V. S.

MAY 27 1957

RECEIVED

05603

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>2 Wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 1 Hancock Md. X2</u>			
f. STREET ADDRESS <u>Rural 1 Hancock Md.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Barnhart</u> Last <u>Barnhart</u>				4. DATE OF DEATH Month <u>5</u> Day <u>30</u> Year <u>1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7.8.1874</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>22</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Labor</u>		11. BIRTHPLACE (State or foreign country) <u>Fulton County Penna.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Barnhart</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Layton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs Laura Barnhart R.F.D. 1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> <u>indeterminate</u> DUE TO (b) <u>Arteriosclerosis generalized</u> <u>indeterminate</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u> <u>None</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>May 29</u> , 19 <u>57</u> , to <u>May 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 30</u> , 19 <u>57</u> , and that death occurred at <u>4:40 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>100 Professional Arts. Bldg. 6-1-57</u> DATE SIGNED <u>W. S. Layman</u> ACTUAL SIGNATURE <u>W. S. Layman</u> M.D. <u>100 Professional Arts. Bldg. 6-1-57</u> PHYSICIAN'S NAME (Type) <u>William T. Layman</u> <u>Hagerstown</u> <u>Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6.3.57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Dot. Fulton County Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Johnson</u>				ADDRESS <u>Hagerstown Md.</u>		24. REC'D BY REGISTRAR <u>June 5, 1957</u>	
25. REGISTRAR'S SIGNATURE <u>Robert H. Bowers</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BUREAU V. 1

JUN 7 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05598

05650

## CERTIFICATE OF DEATH

Reg. Dist. No. 307

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>				c. LENGTH OF STAY IN 1b <b>5 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Williamsport Sanitarium</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Carrie Elizabeth Bower</b>				4. DATE OF DEATH Month Day Year <b>May 26 1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1, 1871</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Shippensburg Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edward Keefer</b>				14. MOTHER'S MAIDEN NAME <b>Frances Shillito</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>---</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Miss Joan Bower Williamsport Rt. 2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443 X</b> DUE TO <b>Hypertensive Cordis Vasculosa Lesion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO <b>---</b> (c) <b>---</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>10-1</b> , 19 <b>56</b> , to <b>5-26</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>5-26-57</b> , 19 <b>57</b> , and that death occurred at <b>7:30</b> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>[Signature]</b>		M.D. <b>[Signature]</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>5/26/57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. E. E. Ditto Jr</b> <b>W. Washington St. Hagerstown Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)			
<b>Burial</b>	<b>5-29-57</b>	<b>Rose Hill Cemetery</b>		<b>Hagerstown Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Scott F. Minnich &amp; Son Hagerstown Md.</b>				24a. REC'D BY REGISTRAR DATE <b>June 3-57</b>		24b. REGISTRAR'S SIGNATURE <b>E Lee McElroy</b>	

RECEIVED



Item 18 Film 216 6-3-57 ams

05651

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LAPPANS RURAL</b>		c. LENGTH OF STAY IN TB <b>17 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>FAIRPLAY MD.R.I</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GOLDYE</b> Middle <b>GERTRUDE</b> Last <b>BOWERS</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>17</b> Year <b>1957</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 27 1901</b>
9. AGE (In years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>WASH.CO.MD.U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>CHARLES E. HAMMOND</b>		14. MOTHER'S MAIDEN NAME <b>LEIDA VANASDLAN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>WALTER C. BOWERS FAIRPLAY MD.R.I</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Breast cancer</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/1/57</b> to <b>5/17/57</b> , that I last saw the deceased alive on <b>5/16/57</b> , and that death occurred at <b>12:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>135 No. Potomac</b> DATE SIGNED <b>5/18/57</b>			
ACTUAL SIGNATURE <b>D. J. Bowers</b> M.D.		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 19 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BAKERSVILLE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>BAKERSVILLE WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home Boonshu md.</b>		24a. REC'D BY REGISTRAR <b>May 19 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>John H. Baird</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 21

MAY 21 1957

RECEIVED

## CERTIFICATE OF DEATH

05652

Reg. Dist. No. 302

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Washington</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Washington</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Hagerstown</u>		LENGTH OF STAY (in this place) <u>8 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Hagerstown</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Brook Lane Farm Route 5</u>				STREET ADDRESS (If rural give location) <u>950 Mulberry Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Elmer Granville Brandenburg</u>				<b>4. DATE OF DEATH</b> (Month) <u>May</u> (Day) <u>20</u> (Year) <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>October 1, 1880</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>		IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - store</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Middletown Fred. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marion Brandenburg</u>				14. MOTHER'S MAIDEN NAME <u>Laura Routzahn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>314-09-7789-A</u>		17. INFORMANT & ADDRESS <u>Mrs. Edith Brandenburg, 950 Mulberry Ave. Hagerstown, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>    </u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>May 13</u> , 19 <u>57</u> , to <u>May 20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 20</u> , 19 <u>57</u> , and that death occurred at <u>4:10 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Herbert Tracer</u> M.D.				ADDRESS (Street, city, town, state) <u>Route 5, Hagerstown, Md.</u>		DATE SIGNED <u>May 20, 1957</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5/23/57</u>		NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md</u>	
24. REC'D BY REGISTRAR DATE <u>May 23, 1957</u>		REGISTRAR'S SIGNATURE <u>Blasht Pavers</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>			

INSTRUCTIONS

**1** hours after death.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this time the bottom copy must be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

RECEIVED

MAY 27 1957

BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

05604

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr Wells  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>2 Hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>TYSON EVERS BRUNNER</u>		4. DATE OF DEATH Month Day Year <u>May 5 1957</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 10 1882</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembly Man Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pleasant Valley Wash Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Brunner</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-18-2187</u>	
17. INFORMANT <u>Robert M. Brunner</u>		Address <u>5 Rosewood Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull (Closed)</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Fell down the basements stairs</u>	
20c. TIME OF INJURY Hour <u>5:30</u> p. m. Month, Day, Year <u>May 5 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 5-6-57	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/9/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>May 9, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert Bowers</u>	



BUREAU V. S.

APR 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05605

## CERTIFICATE OF DEATH

05602

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>65 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>811 S. Potomac St.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Austin</b> Last <b>Burton</b>				4. DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>19 57</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 26, 1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>cabinet maker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>furniture mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Charlottesville, Va.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>John A. Burton</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Foster</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-2573</b>		17. INFORMANT <b>Adelbert Burton, Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331 V</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio sclerosis</b> DUE TO (c) <b>Jeau</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>May 11</b> , 19 <b>51</b> , to <b>May 25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 25</b> , 19 <b>57</b> , and that death occurred at <b>211 N. W. Washington St.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>5/27/57</b>							
ACTUAL SIGNATURE <b>Eldon G. Hoachlander</b> M.D. <b>Hagerstown Md.</b>							
PHYSICIAN'S NAME (Type) <b>Eldon G. Hoachlander, M.D.</b>				115 W. Washington St., Hag., Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-27-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>May 28 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles H. Brown</b>			

RECEIVED

NOV 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 5/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05603

Reg. Dist. No. 305

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL NEAR BOONSBORO</b> c. LENGTH OF STAY IN 1b <b>HOURS</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>BOONSBORO MD. ROUTE 2.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOONSBORO</b> d. STREET ADDRESS <b>north main street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>DANIEL</b> Middle <b>ALBERT</b> Last <b>CASTLE</b>				4. DATE OF DEATH <b>MAY 27 1957</b> Month <b>May</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 29 1916</b> 9. AGE (In years last birthday) <b>41</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MIDDLETOWN FRED. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>J. ALBERT CASTLE</b>				14. MOTHER'S MAIDEN NAME <b>MARY C. SHEPLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS. MARY C. CASTLE BOONSBORO WASH. CO. MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Crushed Spine (Lumbar)</b> <b>835X</b> DUE TO <b>Crushed thoracic region</b> Conditions, if any, which gave rise to immediate cause (b) <b>Hemorrhage and shock</b> (c) <b>Due to</b> (c) <b>cause lost.</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Tractor overturned pinning driver underneath</b>					
20c. TIME OF INJURY <b>12:15 p.m.</b> Month, Day, Year <b>May 27, 1957</b>		20d. INJURY OCCURRED <b>While at work</b> White <input type="checkbox"/> Not white <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Farm</b>		20f. (City or town) <b>Rural Boonsboro Wash Md</b> (County) <b>Washington</b> (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b> EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>5-28-57</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 29 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO CEMETERY</b>		22d. LOCATION (City, town, or county) <b>BOONSBORO WASH. CO. MD.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Friel Boonsboro Md.</b> ADDRESS				24a. REC'D BY REGISTRAR <b>May 29, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>John H. Bass</b>	

BUREAU V. S.

JUN 3 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05606

## CERTIFICATE OF DEATH

05606  
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garlock Nurseing Home</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Jane Pearlre Britner Charlton</b>				4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 2, 1877</b>		9. AGE (In years last birthday) yrs. <b>79</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>10</b> Days <b>3</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House duties</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Berkeley Co., W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Isaac A. Pearlre</b>				14. MOTHER'S MAIDEN NAME <b>Lydia Payne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <b>Mrs. Roger O. Charlton Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. <b>19</b> Month <b></b> Day <b></b> Year <b></b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>never seen alive</b> , and that death occurred at <b>12:01 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard T. Binford</b>				ADDRESS (Street, city or town, state) <b>1135 Potomac Ave Hagerstown, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Richard T. Binford</b>				DATE SIGNED <b>6 May 57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetary</b>		22d. LOCATION (City, town, or county) (State) <b>Martinsburg W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. Brown</b>				ADDRESS <b>Martinsburg W. Va.</b>		24a. REC'D BY REGISTRAR <b>May 10 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Chas. H. Brown</b>			

BUREAU V. S.

MAY 10 1957

RECEIVED

may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05605

05654

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Smithsburg</b>				c. LENGTH OF STAY IN 16 <b>70 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>RFD 1</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Francis</b> Last <b>Cline</b>				4. DATE OF DEATH Month <b>May</b> Day <b>11</b> , Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17, 1871</b>	9. AGE (In years last birthday) <b>86</b> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm work</b>		11. BIRTHPLACE (State or foreign country) <b>Marietta, Ohio</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Levi Cline</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Wolfe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-18-1922</b>		17. INFORMANT <b>Leroy Cline, Smithsburg RD 1, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH. <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. p. _____ m. _____ Month, Day, Year _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>7/10</u> , 19 <u>56</u> to <u>5/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/8</u> , 19 <u>57</u> , and that death occurred at <u>12:35</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. _____ PHYSICIAN'S NAME (Type) <b>Charles Hess, M. D.</b> <b>Smithsburg, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-14-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cem.</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 16 '57</b>		24b. REGISTRAR'S SIGNATURE <u>Charles F. Hess</u>	

BUREAU V. 31

1957

ED

1957

## CERTIFICATE OF DEATH

Reg. Dist. No.

05655  
302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown, Md.</u>		c. LENGTH OF STAY IN 1b <u>49 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Funkstown, Maryland.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cor. Cemetery &amp; Fredrick St.</u>		d. STREET ADDRESS <u>Cor. Cemetery &amp; Fredrick St.</u>	
3. NAME OF DECEASED (Type or print) <u>Emanuel Jacob Craig</u>		4. DATE OF DEATH Month <u>5</u> Day <u>16</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 15 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Window Washer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Emmitsburg, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Jacob Craig</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-09-3225</u>	
17. INFORMANT <u>Eather Craig</u>		Address <u>Funkstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma - Stomach</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 10<sup>th</sup> 1957</u> to <u>May 16<sup>th</sup> 1957</u> , that I last saw the deceased alive on <u>May 10<sup>th</sup> 1957</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>159 W. Washington St., Hagerstown, Md.</u> <u>5/17/57</u>			
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		M.D. <u>159 W. Washington St., Hagerstown, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-18-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R Watson Jr.</u>		ADDRESS <u>Hagerstown Md.</u>	
23a. REC'D BY REGISTRAR <u>May 18, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blasf. Rocers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

MAY 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05656

CERTIFICATE OF DEATH

05607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Ringgold Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Ringgold	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hagerstown Md., #5		d. STREET ADDRESS Hagerstown #5	
3. NAME OF DECEASED (Type or print) First Eugene Middle Keller Last Creager		4. DATE OF DEATH Month May Day 17 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/24/1873
9. AGE (In years last birthday) 83 yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Vulcan Machine Co.	
11. BIRTHPLACE (State or foreign country) Ringgold Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin Creager		14. MOTHER'S MAIDEN NAME Annie King	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO 17. INFORMANT Miss Hazel Creager, Ringgold Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio-sclerotic Cardiovascular</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dissecting - Aortic Coarctation</u> DUE TO (c) <u>Failure - Right Pulmonary valve</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Three</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12-28-56</u> , 19 <u>56</u> , to <u>5-18-57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5-17-57</u> , 19 <u>57</u> , and that death occurred at <u>4:50</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. W. Lindeman</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Washington, D.C.</u> <u>5-18-57</u>	
PHYSICIAN'S NAME (Type) C. W. LINDEMAN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/20/57	22c. NAME OF CEMETERY OR CREMATORY Ringgold	22d. LOCATION (City, town, or county) (State) Hagerstown, Washington Md., #5
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. ...</u>		24a. RECEIVED BY REGISTRAR DATE MAY 21 1957	24b. REGISTRAR'S SIGNATURE <u>...</u>

BUREAU V. S.

MAY 21 1957

RECEIVED

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>		c. LENGTH OF STAY IN 1b <b>20 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown, Maryland</b>		d. STREET ADDRESS <b>421 B. Sumans Ave.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>						• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sara</b>		First <b>Elizabeth</b>		Middle <b>Clark</b>		Last <b>May</b>	
5 SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF DEATH Month <b>May</b>	
9 AGE (In years last birthday) <b>38</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private family</b>		10c. DATE OF BIRTH <b>May 29 1919</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>David Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Myrtle Brookins Hagerstown, Md.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>215-20-3705</b>		17. INFORMANT <b>Mrs. Myrtle Robinson</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Burns of torso &amp; thighs. 3rd degree</b> DUE TO <b>Pulmonary Embolism.</b> DUE TO <b>Coronal Embolism</b>		INTERVAL BETWEEN ONSET AND DEATH <b>20 days</b>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Bed clothes caught fire</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Hagerstown Wash. Maryland</b>	
21. I certify that I attended the deceased from <b>May 11th., 1957.</b> to <b>May 31st., 1957.</b> that I last saw the deceased alive on <b>May 30th., 1957.</b> and that death occurred at <b>4 A.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>159 W. Washington St.</b>		DATE SIGNED <b>6/3/57</b>		ACTUAL SIGNATURE <b>Philip J. Hirshman</b>		PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1141</b>		22b. DATE THEREOF <b>6-3-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R Watson Jr.</b>		ADDRESS <b>Hagerstown Md.</b>		24. REC'D BY REGISTRAR <b>June 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas H Bowers</b>	

BUREAU V. 11

JUN 12 1967

RECEIVED

100-257-1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be filed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05608

## CERTIFICATE OF DEATH

06809  
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>7 days</u>				d. STREET ADDRESS <u>R.F.D. # 5</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Isacc</u> Last <u>Coss</u>				4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 17, 1904</u>		9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>9</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>State Penal Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Leitersburg, Md. Rural</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William S. Coss</u>				14. MOTHER'S MAIDEN NAME <u>Emma Kate Justice</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-09-0898</u>		17. INFORMANT Address <u>Mrs. Thelma A. Coss Hagerstown, Maryland Rt. 5</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>Arterio Sclerosis (Circul)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>2 yrs.</u> <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat whle <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 20, 1957</u> to <u>May 26, 1957</u> , that I last saw the deceased alive on <u>May 26, 1957</u> , and that death occurred at <u>6:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Beachley</u> M.D.				ADDRESS (Street, city or town, state) <u>Hagerstown</u> DATE SIGNED <u>May 27, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/29/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. Franklin Rouzer</u>				ADDRESS <u>Hagerstown, Md.</u>		24. REC'D BY REGISTRAR <u>June 3, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Bowers</u>			

RECEIVED  
JUN 12 1957  
BUREAU V. S.

05609

## CERTIFICATE OF DEATH

Reg. Dist. No.

370

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>50 years</u>				d. STREET ADDRESS <u>400 Summit Avenue</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hollers Apts. 400 Summit Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Gack</u> Last <u>Gack</u>				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1877</u>		9. AGE (in years last birthday) <u>79 yrs.</u>	IF UNDER 1 YEAR: Months <u>5</u> Days <u>15</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (State or foreign country) <u>County Cork, Ireland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Sweeney</u>			
14. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>			
16. SOCIAL SECURITY NO. <u></u>				17. INFORMANT Address <u>Mrs. Viola A. Stittler, Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusions</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u> <u>? 10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>				20g. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>5/19/54</u> 19 <u>54</u> , to <u>5/12/57</u> 19 <u>57</u> , that I last saw the deceased alive on <u>5/12/57</u> , 19 <u>57</u> , and that death occurred at <u>12 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert V. L. Campbell</u> M.D.				ADDRESS (Street, city or town, state) <u>145 W Washington St Hagerstown Md</u>			
DATE SIGNED <u>5/13/57</u>							
PHYSICIAN'S NAME (Type) <u>Robert V. L. Campbell</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-15-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> ADDRESS <u>Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>May 17, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Frank H. Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU A. M.

MAY 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05610

## CERTIFICATE OF DEATH

05609

Reg. Dist. No.

302

1 PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>				e. STREET ADDRESS <b>13 N. Main St.</b>			
3 NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>Florence</b> Last <b>Gardner</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>57</b>			
5 SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1874</b>	9. AGE (In years last birthday) <b>82</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11 BIRTHPLACE (State or foreign country) <b>Cavetown, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Reynolds</b>				14. MOTHER'S MAIDEN NAME <b>Sally Reynolds</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>George H. Gardner, Smithsburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Arteriosclerosis Generalized</b> DUE TO (c) <b>3 days</b> <b>3 yrs.</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. <b>11</b> p. m. Month <b>19</b> Day <b>19</b> Year <b>1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>9/16</b> , 19 <b>54</b> , to <b>5/1</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>4/30</b> , 19 <b>57</b> , and that death occurred at <b>1:24</b> A.M. from the causes and on the date stated above							
ACTUAL SIGNATURE <b>Charles F. Hess</b> M.D.				ADDRESS (Street, city or town, state)			
PHYSICIAN'S NAME (Type) <b>Charles F. Hess, M. D.</b>				<b>Smithsburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5-3-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>	22d. LOCATION (City, town, or county)	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>			24a. REC'D BY REGISTRAR <b>May 3, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Shack Bowers</b>			

RECEIVED  
MAY 6 1957  
BUREAU V. S.

05657

CERTIFICATE OF DEATH

06815

Reg. Dist. No.

316

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KEEDYSVILLE</b>				c. LENGTH OF STAY IN TB <b>65 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>KEEDYSVILLE MD.</b>				d. STREET ADDRESS <b>KEEDYSVILLE MD.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>E.</b> Last <b>GEETING</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 22 1869</b>	9. AGE (In years last birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BOONSBORO WASH.CO.MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALFRED C. HUFFER</b>				14. MOTHER'S MAIDEN NAME <b>SARAH TOMS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>		17. INFORMANT <b>RUSSEL H. GEETING KEEDYSVILLE MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m p. m <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 10, 1947</b> to <b>May 16, 1957</b> , that I last saw the deceased alive on <b>May 16, 1957</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. W. Lelvan</b> M.D.				ADDRESS (Street, city or town, state) <b>Boonsboro Maryland</b> DATE SIGNED <b>5/18/57</b>			
PHYSICIAN'S NAME (Type) <b>G. W. Lelvan</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAY 19 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FAIRVIEW CEMETERY</b>		22d. LOCATION (City, town or county) (State) <b>KEEDYSVILLE WASH.CO.MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bad Funeral Home</b> ADDRESS <b>Boonsboro Md</b>				24a. REC'D BY REGISTRAR <b>DATE 5-17-57</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Geeting</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUL 1 1967

BUREAU V. S.

05658

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>				c. LENGTH OF STAY IN 1b <b>18 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reeders Nursing Home</b>				e. STREET ADDRESS <b>Route 4</b>			
3. NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle <b>Dean</b> Last <b>Gerhart</b>				4. DATE OF DEATH Month <b>May</b> Day <b>6</b> Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 14, 1881</b>	
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Big Pool Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Frank Zimmerman</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Repp</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>---</b>		17. INFORMANT Address <b>Mrs. Nellie V. Eyler Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crowning Thrombosis infection</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>intermediate</b> DUE TO (c) <b>no.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4 hrs</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on <b>May 5</b> , 19 <b>57</b> , and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 E. Antietam St.</b> DATE SIGNED <b>5/6/57</b>							
ACTUAL SIGNATURE <b>Louis G. Graff</b> M.D. <b>119 E. Antietam St.</b>				PHYSICIAN'S NAME (Type) <b>Dr. Louis G. Graff</b> <b>119 East Antietam St. Hagerstown Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-9-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Clearspring Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>May 11 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Blair H. Boevers</b>			

BUREAU V. S.

1 1957

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

05659

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05611

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>6 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>Route 6</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emil Michael Gertz</b>				4. DATE OF DEATH <b>May 22 19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 13, 1888</b>		9. AGE (In years last birthday) <b>68</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Michael Gertz</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Schneider</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes W. W. 1</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Sheriff Office Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute and chronic coronary thrombosis</b> <b>OR 2-X</b> DUE TO Tuberculosis of lungs with cavity formation Conditions, if any, which gave rise to immediate cause (b) <b>Old pulmonary Embolism</b> (c) DUE TO cause last, (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>						INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>None 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>- - -</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-24-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Wash. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnick &amp; Sons</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>May 27 1957</b>	
						24b. REGISTRAR'S SIGNATURE <b>Phas H Bowers</b>	



RECEIVED

MAY 29 1957

BUREAU V. S.

05611

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 Day</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>164 W. Washington St</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Nnnamed baby boy of Robert Goff</u> First Middle Last 4. DATE OF DEATH <u>May 8 1957</u> Month Day Year				5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 7 1957</u> 9. AGE (In years last birthday) yrs. <u>1</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u> IF UNDER 24 HRS: Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u> 11. BIRTHPLACE (State or foreign country) <u>Md</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Robert Goff</u> 14. MOTHER'S MAIDEN NAME <u>Nancy Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Robert Goff</u> Address <u>164 W. Washington St Hagerstown Md.</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO (b) <u>Premature Delivery - Section</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Partial Premature Separation Placenta</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-----</u> INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Samuel F. Waddell</u> <u>115 King St. Hagerstown</u> <u>5-8-57</u> PHYSICIAN'S NAME (Type) <u>Samuel F. Waddell</u> <u>115 King St., Hagerstown</u>				22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>5/9/57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u> ADDRESS <u>Hagerstown Md.</u> 24a. REC'D BY REGISTRAR <u>May 13/1957</u> 24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be used for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 15 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 05660  
 CERTIFICATE OF DEATH

06817

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Security</b>				c. LENGTH OF STAY IN 1b <b>48 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>516 Antietam Drive</b>				d. STREET ADDRESS <b>516 Antietam Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>W.</b> Last <b>GRIMM</b>				4. DATE OF DEATH Month <b>May</b> Day <b>31</b> , Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 17, 1888</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Postmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>Washington Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles M. Grimm</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Holmes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-03-5111</b>		17. INFORMANT Address <b>Mrs. Edward Ridenour 1126 Security Rd. Security, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-Sclerotic Heart Disease with</b> <b>100.0</b> DUE TO <b>Myocardial Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May</b> , 1952, to <b>31 May</b> , 1957, that I last saw the deceased alive on <b>31 May</b> , 1957, and that death occurred at <b>5:45 P.</b> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F. F. Lusby</b>				ADDRESS (Street, city or town, state) <b>2301 Potomac</b>		DATE SIGNED <b>1 June 57</b>	
PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>				<b>Hagerstown, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 3, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>June 3, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Bowers</b>	

Wm. C. Honor C. M.

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BUREAU V. S.

05612

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>47 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>926 Mt. Etna Road</b>				d. STREET ADDRESS <b>926 Mt. Etna Road</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>GRACE</b> Last <b>GROSSNICKLE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1893</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Caleb H. Grossnickle</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte A. Kinna</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>none</b>		17. INFORMANT <b>930 Mt. Etna Road, Mary E. Grossnickle, Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arricular Fibrillation due to Arterio</b> (c) <b>sclerotic heart disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b> <b>few minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 Apr</b> 1957, to <b>16 May</b> 1957, that I last saw the deceased alive on <b>11 May</b> 1957, and that death occurred at <b>9 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>F F Lusby</b>				ADDRESS (Street, city or town, state) <b>230 N Potomac</b>		DATE SIGNED <b>17 May 57</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Frank F. Lusby</b>				<b>230 N. Potomac St. Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Grossnickle's</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Myersville, Fred. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul F. Bittle</b>				ADDRESS <b>Myersville, Md.</b>		24a. REC'D BY REGISTRAR <b>May 11 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 20 1957

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may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05613

CERTIFICATE OF DEATH

Reg. Dist. No.

05614

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>10 Days</u>				d. STREET ADDRESS <u>985 Jefferson Blvd.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Abbie</u> Middle <u>Kate</u> Last <u>Grove</u>				4. DATE OF DEATH Month <u>May</u> Day <u>23</u> Year <u>19 57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1881</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>20</u>	IF UNDER 24 HRS Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Henry Stull</u>				14. MOTHER'S MAIDEN NAME <u>Emma K. Kidwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Henry Carroll</u> Address <u>985 Jefferson Blvd. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line of (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis of Leg &amp; Gangrene</u> <u>450.1</u> DUE TO <u>Arterio Sclerosis (General)</u> 5 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Centrally Arterio Sclerosis</u> 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 18, 1957</u> to <u>May 20, 1957</u> , that I last saw the deceased alive on <u>May 23, 1957</u> , and that death occurred at <u>10:15 PM</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hagerstown, MD</u> DATE SIGNED <u>May 24/57</u>							
ACTUAL SIGNATURE <u>J. H. Beachley</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Dr. Jack H. Beachley M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 26, '57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Sharpsburg, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Zapp</u> ADDRESS <u>Washington, Md.</u>				24. REC'D BY REGISTRAR <u>May 24, 1957</u>		24a. REGISTRAR'S SIGNATURE <u>Shawn H. Bowers</u>	



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MAY 27 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05615

05614

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md. X	
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 21 W. Potomac Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Susan Elsie Grove				4. DATE OF DEATH Month Day Year May 27 1957			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 12 1881		9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months Days Hours Min 9 14
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Jefferson Co. W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Lemen				14. MOTHER'S MAIDEN NAME Annie Busey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO (If yes, give war or dates of service) None		17. INFORMANT Mr. Joseph G. Grove Williamsport Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 14. 1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 Day							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/26/57 19 to 5/27/57 19, that I last saw the deceased alive on 5/27/57 19, and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Ralph F. Young M.D. Williamsport, Md. 5/27/57							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 29-57		22c. NAME OF CEMETERY OR CREMATORY Mt. Hebron Cemetery		22d. LOCATION (City, town or county) (State) Winchester W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE William G. Bowers				ADDRESS Williamsport, Md.		24a. REC'D BY REGISTRAR May 29, 1957	
				24b. REGISTRAR'S SIGNATURE Wm. G. Bowers			

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05615

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>29 YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			
f. STREET ADDRESS <b>1812 MULBERRY AVE.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>PAULINE LUCINDA HEALEY</b>				4. DATE OF DEATH Month Day Year <b>MAY 10 19 57</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/26/1918</b>	9. AGE (In years last birthday) <b>38 yrs</b>	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PAUL S. GLUCK</b>				14. MOTHER'S MAIDEN NAME <b>MARY RINEDOLLAR</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-30-3926</b>		17. INFORMANT <b>MR. RALPH HEALEY HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized Abdominal Cancer 7 mos</b> 175x DUE TO <b>Adenocarcinoma Rt Ovary 7 mos</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-28-48</b> , 19____, to <b>5-10-57</b> , 19____, that I last saw the deceased alive on <b>5-10-57</b> , 19____, and that death occurred at <b>6:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>5/12/57</b> ACTUAL SIGNATURE <b>S. EARL YOUNG</b> PHYSICIAN'S NAME (Type) <b>S. EARL YOUNG</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.J. Normant</b>				ADDRESS <b>Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>May 15, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 17 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05616

## CERTIFICATE OF DEATH

05617

Reg. Dist. No. 342

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. LENGTH OF STAY IN 1b <b>40YRS.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>NEWTON</b> Last <b>HENSON</b>				4. DATE OF DEATH Month <b>MAY</b> Day <b>23</b> Year <b>19 57</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/12/1915</b>	
9. AGE (In years last birthday) <b>42 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CEMENT CO.</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>CLYDE HENSON</b>				14. MOTHER'S MAIDEN NAME <b>GRACE MESSER</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>214-09-4983</b>		17. INFORMANT <b>MRS. NELLIE HENSON</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>443X</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C.V. disease</b> DUE TO (c) <b>Unknown</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>Unknown</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Aug 6</b> , 19 <b>55</b> , to <b>May 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 23</b> , 19 <b>57</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L.L. Packer Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>5/25/57</b>			
NAME (Type) <b>L.L. PACKER JR.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.J. Norment, Hagerstown, Md</b>				24a. REC'D BY REGISTRAR <b>May 27, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blair H. Bowers</b>	

BUREAU V. S.

MAY 29 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
05661 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05618

Reg. Dist. No. 301

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Berkeley</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marlowe</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac River Dam at P.E.</u>				d. STREET ADDRESS <u>Marlowe W. Va.</u>			
3. NAME OF DECEASED (Type or print) First <u>Marvin</u> Middle <u>Oliver</u> Last <u>High</u>				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1939</u>		9. AGE (In years last birthday) <u>17 yrs.</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>22</u>	IF UNDER 24 MRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tree Trimming</u>		11. BIRTHPLACE (State or foreign country) <u>Berkeley Co. West Vir.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ralph High</u>				14. MOTHER'S MAIDEN NAME <u>Lillian O'Neal</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-36-2166</u>		17. INFORMANT <u>Ralph High</u>		Address <u>Marlowe, West Virginia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation by drowning</u> DUE TO <u>929.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while trying to rescue boat in water</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>X 3 36</u> Min. <u>X 20</u> <u>May 3 19 57</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>River</u>		20f. (City or town) (County) (State) <u>Williamsport Wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5-8-59</u>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 9, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Harmony Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Marlowe West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Lee</u>				24a. REC'D BY REGISTRAR <u>May 9-1957</u>		24b. REGISTRAR'S SIGNATURE <u>E. Lee McElroy</u>	



RECEIVED  
MAY 13 1957  
BUREAU OF

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>457 SUMMIT AVE.</b>		d STREET ADDRESS <b>457 SUMMIT AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First Middle Last <b>CHARLES CLINTON HOFFMASTER</b>		4. DATE OF DEATH Month Day Year <b>MAY 24 19 57</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>WHITE</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/23/1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CLERK</b>		10b KIND OF BUSINESS OR INDUSTRY <b>WHOLESALE GROCER</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13 FATHER'S NAME <b>SAMUEL HOFFMASTER</b>		14 MOTHER'S MAIDEN NAME <b>MARY ROHRER</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <b>NO</b>		16 SOCIAL SECURITY NO. <b>214-09-7708A</b>	
17 INFORMANT <b>MRS. MARY N. HOFFMASTER</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>			
331X DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11-1-1955</b> to <b>5-24-1957</b> that I last saw the deceased alive on <b>4-24-57</b> , 19____, and that death occurred at <b>9 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. E. W. Hitt Jr.</b> M.D.		DATE SIGNED <b>5/24/57</b>	
PHYSICIAN'S NAME (Type) <b>Hagerstown Md</b>			
22a BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/27/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. VIEW CEM.</b>	22d LOCATION (City, town, or county) (State) <b>SHARPSBURG MD.</b>
23 FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant, Hagerstown, Md.</b>		24a REC'D BY REGISTRAR <b>May 28, 1957</b> 24b REGISTRAR'S SIGNATURE <b>Phas H. Bowers</b>	

MEDICAL CERTIFICATION

BUREAU V. S.

MAY 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 05662 CERTIFICATE OF DEATH

Reg. Dist. No.

05620

303

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL CLEAR SPRING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Clear Spring Md</u>			
c. LENGTH OF STAY IN 1b <u>30 YEARS</u>				d. STREET ADDRESS <u>ROUTE 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Clear Spring Rt 2</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>ILBERT</u> Last <u>RUSSELL</u>			4. DATE OF DEATH Month <u>5</u> Day <u>2</u> Year <u>1957</u>				
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 4, 1903</u>		9. AGE (In years last birthday) yrs. <u>53</u>	IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>57</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SA. MEL REED</u>				14. MOTHER'S MAIDEN NAME <u>PLT BLOYER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>RUSSELL F. HOSE</u> Address <u>CLEAR SPRING MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery atherosclerosis</u> DUE TO (c) <u>unknown</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1. Diabetes mellitus 2. Nephrosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 27, 1956</u> to <u>May 2, 1957</u> , that I last saw the deceased alive on <u>April 1, 1956</u> , and that death occurred at <u>3:15 am</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Clear Spring, Maryland</u> DATE SIGNED <u>5/3/57</u>							
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Archie Robert Cohen, M.D.</u> <u>Clear Spring, Maryland</u> <u>5/3/57</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>AY 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BLAIRS VALLEY</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON CO., MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> Address <u>Clear Spring, Md</u>				24a. REC'D BY REGISTRAR <u>May 4-57</u>		24b. REGISTRAR'S SIGNATURE <u>Joseph W. Murray</u>	

RECEIVED

MAY 7 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05663

## CERTIFICATE OF DEATH

Reg. Dist. No.

05621  
30.4

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock Maryland.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Hancock Maryland.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				e. STREET ADDRESS <u>204 E Terrace</u>			f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Melvin</u> Last <u>Iden</u>				4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8.23.1882</u>		9. AGE (In years last birthday) <u>74</u> yrs	IF UNDER 1 YEAR Months <u>9</u> Days <u>1</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming (Retired)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Morgan County W.VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Parkson Iden</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Iden.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mrs Katherine R Collins</u>		Address <u>Hancock Md. 200 E. Terrace</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary disease</u> DUE TO <u>arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2da</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u></u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u>				20g. (County) <u></u>		20h. (State) <u></u>	
21. I certify that I attended the deceased from <u>5/22/57</u> to <u>5/24/57</u> , that I last saw the deceased alive on <u>5/22/57</u> , and that death occurred at <u>2:15 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>H.M. Shopper</u>				ADDRESS (Street, city or town, state) <u>Hancock Md.</u>			
PHYSICIAN'S NAME (Type) <u></u>				DATE SIGNED <u>5/24/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5.26.57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stotlers Cross Roads W.VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone</u>				ADDRESS <u>Hancock Md.</u>		24a. RECEIVED BY REGISTRAR DATE <u>5/24/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>H. Neeller</u>			

RECEIVED  
MAY 27 1957  
BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 05664 CERTIFICATE OF DEATH

Reg. Dist. No

05622  
347

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b> c. LENGTH OF STAY IN 1b <b>5 Weeks</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Williamsport Sanatorium</b>		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>808 West Franklin St</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>EDNA</b> Last <b>JOHNSON</b>		4. DATE OF DEATH Month <b>May</b> Day <b>26</b> Year <b>1957</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 31 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State) <b>Montgomery Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James E. Garrett</b>		14. MOTHER'S MAIDEN NAME <b>Mary H. Byrne</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>----</b>		16. SOCIAL SECURITY NO <b>None</b>	
17. INFORMANT <b>Ernest Johnson 808 W. Franklin St</b>		Address <b>Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442X DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Vascular Disease</b> DUE TO (c) <b>Stroke</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-1-57</b> , 19 <b>57</b> , to <b>5-26-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>5-24-58</b> , 19 <b>58</b> , and that death occurred at <b>5:30</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown Md.</b> DATE SIGNED <b>5/26/58</b>			
ACTUAL SIGNATURE <b>Andrew K. Coffman</b> M.D.		PHYSICIAN'S NAME (Type) <b>Andrew K. Coffman</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/29/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Gaithersburg Montgomery Co Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>John P. 576</b>		24b. REGISTRAR'S SIGNATURE <b>John P. 576</b>	



RECEIVED

JUN 5 1937

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05618

## CERTIFICATE OF DEATH

Reg. Dist. No.

15623  
302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>			
c. LENGTH OF STAY IN 1b <b>12 YEARS</b>				d. STREET ADDRESS <b>1062 SOUTH POTOMAC STREET</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1062 SOUTH POTOMAC STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>BESSIE MAE KEPHART</b>				4. DATE OF DEATH Month Day Year <b>MAY 4 1957 19</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPTEMBER 7 1899</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		11. BIRTHPLACE (State or foreign country) <b>HARMONY FRED. CO. MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EDWARD L. BABBINGTON</b>				14. MOTHER'S MAIDEN NAME <b>JENNIE V. HARSHMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <b>217 32 5349</b>			
17. INFORMANT <b>JOHN T. KEPHART</b>				Address <b>1062 S. POTOMAC ST HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocardial infarction</b> <b>4 x 0.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Hypertensive Cardiovascular disease</b> (c) <b>and Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
27. I certify that I attended the deceased from <b>Aug 8, 1956</b> to <b>May 4, 1957</b> , that I last saw the deceased alive on <b>Feb 7, 1957</b> , and that death occurred at <b>5:12 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>217 W. Washington St., Hagerstown, Md.</b>				DATE SIGNED <b>5/6/57</b>			
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>							
PHYSICIAN'S NAME (Type) <b>Edward W. Ditto III, M.D.</b>				Address <b>217 W. Washington St., Hagerstown, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<b>BURIAL</b>		<b>MAY 7 1957</b>		<b>LUTHERAN CEMETERY</b>		<b>MIDDLETOWN FRED. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Best Funeral Home Boonsboro Wash. Co. Md.</b>				24a. REC'D BY REGISTRAR <b>May 9, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

MAY 18 1957

RECEIVED

05619

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>		d. STREET ADDRESS <b>2006 Virginia Ave</b>	
3. NAME OF DECEASED (Type or print) <b>HARRY DOUGLAS LEFEVER</b>		4. DATE OF DEATH <b>May 10 1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 2 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>George Lefever</b>		14. MOTHER'S MAIDEN NAME <b>Mary Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Minnie K. Lefever</b>		Address <b>2006 Virginia Ave</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>arteriosclerotic myocardial heart disease</b> DUE TO (c) <b>arteriosclerotic myocardial heart disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b> <b>5 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b> 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 9, 1952</b> , to <b>May 10, 1957</b> , that I last saw the deceased alive on <b>May 9, 1957</b> , and that death occurred at <b>12:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>		DATE SIGNED <b>5-10-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/12/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>May 13 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAY 15 1957

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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05665

05620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Smithsburg</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Foxville, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>County Road near Smithsburg</u>			d. STREET ADDRESS		e. IS RES. RES. ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Roscoe</u> Last <u>Lewis</u>			4. DATE OF DEATH Month <u>May</u> Day <u>2</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 5, 1937</u>	9. AGE (In years last birthday) <u>19</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Roscoe Lewis</u>			14. MOTHER'S MAIDEN NAME <u>Hattie Lewis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Yes</u> <u>1955-1957</u>		16. SOCIAL SECURITY NO <u>214-34-9716</u>		17. INFORMANT <u>Sister</u> via <u>Creager's Funeral Home</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull and internal injuries</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>immed.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Lost control of auto. pinned under wreck.</u>			
20c. TIME OF INJURY Month, Day, Year <u>1:00 PM</u> <u>5/2</u> <u>1957</u>		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>County Road</u> <u>Smithsburg, Washing. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> , M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
NAME (Type) <u>Edward W. Ditto III, M.D.</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Bethel Methodist Cem. Near Garfield, Frank Co.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Creager</u>			24a. REC'D BY REGISTRAR <u>  </u> DATE <u>5/2/57</u>		
ADDRESS <u>Thurmont, MD</u>			24b. REGISTRAR'S SIGNATURE <u>  </u>		

RECEIVED

MAY 6 1957

BUREAU V. S.

05666

CERTIFICATE OF DEATH

Reg. Dist. No. 343

05626

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penn</b> b. COUNTY <b>Fulton</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McConnellsburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gateway Nursing Home</b>		d. STREET ADDRESS	
3 NAME OF DECEASED (Type or print) First <b>Annie</b> Middle <b>Catherine</b> Last <b>Lininger</b>		4. DATE OF DEATH Month <b>May</b> Day <b>12</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <b>67</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Foulton Co. Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Michael Kanuff</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Barmont</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Nettie Booth McConnellsburg Pa</b>		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chr. Endocarditis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>430.0</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 17, 1957</b> to <b>May 12, 1957</b> , that I last saw the deceased alive on <b>May 11, 1957</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.		DATE SIGNED <b>5/13/57</b>	
PHYSICIAN'S NAME (Type) <b>David Brewer</b>		<b>Clearspring Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-15-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mc Connellsburg Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE May 18-57</b>		24b. REGISTRAR'S SIGNATURE <b>Leroy M. Fickler</b> (Hagerstown)	



BUREAU V. 81

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RECEIVED

05620

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON COUNTY HOSPITAL</b>		d. STREET ADDRESS <b>124 EAST AVE.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First <b>CHARLOTTE</b> Middle <b>AMELIA</b> Last <b>LIZER</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>26</b> Year <b>19 57</b>	
5 SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/1900</b>
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NORMAN BOWERS</b>		14 MOTHER'S MAIDEN NAME <b>HENRETTA STAUBS</b>	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <b>NO</b> (If yes, give war or dates of service)		16 SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>MRS. MILDRED MORRISON</b>		Address <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease.</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 mos</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21 I certify that I attended the deceased from <b>March 9, 19 56</b> to <b>May 26, 19 57</b> , that I last saw the deceased alive on <b>May 25, 19 57</b> , and that death occurred at <b>12:50 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 North Potomac St. Hagerstown, Maryland.</b> DATE SIGNED <b>5-27-57</b>			
ACTUAL SIGNATURE <b>R. A. Bell</b>		M D	
PHYSICIAN'S NAME (Type) <b>R. A. Bell, M. D.</b>		<b>Hagerstown, Maryland.</b>	
22a. BURIAL, CREMATION, MORTUARY (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>5/28/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>HAGERSTOWN MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Normant, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>May 31, 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowers</b>

TO HOSPITAL OR ATTENDING PHYSICIAN. The low requires that the death certificate be executed within 24 hours after death: Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW YORK

JUN 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05628

05621

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. LENGTH OF STAY IN 1b 12 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 836 Spruce Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.	
3. NAME OF DECEASED (Type or print) First Eliza Middle Jane Last Mc Elroy		4. DATE OF DEATH Month May Day 13 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29 1881
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 9 Days 14 Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Taylors Landing Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Mc Coy		14. MOTHER'S MAIDEN NAME Elizabeth Hammond	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. George McElroy		Address 836 Spruce St. Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>Day</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/12/57 to 5/13/57, that I last saw the deceased alive on 5/13/57, and that death occurred at 6:00 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Ralph F. Young</i> M.D.		DATE SIGNED 5/13/57	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 22-57	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert J. ...</i>		24a. REC'D BY REGISTRAR May 14 1957	
24b. REGISTRAR'S SIGNATURE <i>W. H. ...</i>			

BUREAU V. 31

1957

LIBRARY

05622

CERTIFICATE OF DEATH

05622

Reg. Dist. No.

302

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2 USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last BLANCHE BELLE MCKINSEY		4. DATE OF DEATH Month MA Year YBERT. Day 27 Year 19 57	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 9/28/1892
9. AGE (In years last birthday) 64rs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY WOLFE		14. MOTHER'S MAIDEN NAME CORA DELAUDER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO none	
17. INFORMANT LOUISE MCKINSEY, HAGERSTOWN, MD.		Address	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 176X DUE TO Carcinoma of Vaginal wall Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Metastasis to large bowel DUE TO Intestinal obstruction (c) INTERVAL BETWEEN ONSET AND DEATH 3 yrs 17 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. None 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) None		20f. (City or town) (County) (State)	
21 I certify that I attended the deceased from Oct. 1942, to Nov 27, 1957, that I last saw the deceased alive on May 27, 1957, and that death occurred at 10:30 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE S. Robert Wells M.D.		ADDRESS (Street, city or town, state) 115 N. Potomac Street DATE SIGNED 5-27-57	
PHYSICIAN'S NAME (Type) S. Robert Wells, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 5/30/57	22c. NAME OF CEMETERY OR CREMATORY SMITHSBURG CEMETERY	22d. LOCATION (City, town, or county) SMITHSBURG MD. (State)
23 FUNERAL DIRECTOR'S SIGNATURE W. J. Norment Hagerstown, Md.		24a. REC'D BY REGISTRAR 6/1/57 24b. REGISTRAR'S SIGNATURE Blanche Powers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 3 1957

STANLEY V. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										05630
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 302
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro R # 1</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. County Hospital</u>					d. STREET ADDRESS <u>Breathedsville Road</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>VICTOR BRUCE McLAUGHLIN D.D.S.</u>					4. DATE OF DEATH Month Day Year <u>May 4 1957</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 13 1898</u>		9. AGE (In years last birthday) <u>58</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>Co USA</u>				
13. FATHER'S NAME <u>Henry Prather McLaughlin</u>					14. MOTHER'S MAIDEN NAME <u>Anna A. Zeller</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>					16. SOCIAL SECURITY NO. <u>W.W.# 1 212-38-8620</u>		17. INFORMANT Address <u>Mary R. McLaughlin Boonsboro Md R # 1</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial heart failure (acute decompensation)</u> <u>Undetermined / Pending Autopsy / Report</u> DUE TO <u>Multiple contusions to body &amp; lacerations to</u> <u>liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>liver</u> DUE TO <u>Trauma by automobile collision</u> <u>advanced severe coronary arterio-sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>816x</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>Head-on Automobile collision</u>					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u>1:00</u> a.m. <u>PM</u> Month, Day, Year <u>May 4 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Rural Tiltmington Wash Md</u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE <u>S. Robert Wells</u> EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-6-57</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Andrew K. Coffman Hagerstown Md.</u>					24a. REC'D BY REGISTRAR <u>May 13 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Blair H. Gessner</u>			



BUREAU V. S.

MAY 15 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the City of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05624

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr. Wells

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Cty. Hospital</u>				d. STREET ADDRESS <u>2005 Penna. Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Fannie Grace McNairn</u>				4. DATE OF DEATH Month Day Year <u>May 17 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1908</u>	9. AGE (in years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John H. Petre</u>				14. MOTHER'S MAIDEN NAME <u>Mary Byers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-34-1182</u>		17. INFORMANT <u>John D. McNairn</u>		Address <u>Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cerebral Hemorrhage</u> DUE TO <u>Vascular hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>447X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>					
20c. TIME OF INJURY Hour a. m. p. m. <u>none</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>- - -</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>S. Robert Wells</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-20-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Long Meadow Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Paramount, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>May 20, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>S. Robert Wells</u>	

MEDICAL CERTIFICATE

BUREAU V. 1

NOV 23 1957

RECEIVED

Reg. Dist. No. 905

VS AIS (4)  
ISM 9/55

BUREAU V. 41

MAY 15 1957

RECEIVED

6841

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			c. LENGTH OF STAY IN 1b <b>10 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>				d. STREET ADDRESS <b>540 Summit Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle <b>Lee</b> Last <b>Moats</b>				4. DATE OF DEATH Month <b>5</b> Day <b>29</b> Year <b>19 57</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 10, 1892</b>		
9. AGE (In years last birthday) <b>65</b> yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Fairehilds</b>		11. BIRTHPLACE (State or foreign country) <b>Tilghmanton, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Moats</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Rohrer</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>214-09-8464</b>		17. INFORMANT <b>Mrs. Carl L. Moats</b>		Address <b>Hagerstown, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19 57</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>May 29, 19 57</b> to <b>May 29, 19 57</b> , that I last saw the deceased alive on <b>May 28, 19 57</b> , and that death occurred at <b>9:10 A</b> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>119 North Potomac St., Hagerstown, Md.</b> DATE SIGNED <b>May 31, 1957</b>								
ACTUAL SIGNATURE <i>R. A. Bell</i>			M. D. <b>Hagerstown, Maryland.</b>					
PHYSICIAN'S NAME (Type) <b>R. A. Bell, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Free W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 3, 1957</b>		
				24b. REGISTRAR'S SIGNATURE <i>Free W. Kraiss</i>				

MEDICAL CERTIFICATION

RECEIVED

JUN 12 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05625

## CERTIFICATE OF DEATH

Dr. L. L. Packer  
05633  
Reg. Dist. No. 302

1 PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN b. <b>5 Days</b> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <b>Washington Co. Hospital</b>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> d. STREET ADDRESS <b>143 Alexander Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>IRA</b> Middle <b>CLAY</b> Last <b>MYERS</b>		4 DATE OF DEATH Month <b>May</b> Day <b>21</b> , 1957 Year <b>19</b>	
5 SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct. 25/1894</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Conductor W.R.R.</b>	11. BIRTHPLACE (State or foreign country) <b>Millstone, Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alexander Myers</b>	
14. MOTHER'S MAIDEN NAME <b>Della Myers</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W.W. #1</b>	
16 SOCIAL SECURITY NO <b>705-10-5348</b>		17. INFORMANT <b>Mrs Belva H. Myers</b> Address <b>143 Alexander St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last (b) <b>Nephrotic disease</b> (c) <b>Hypertensive C. V. disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>Unknown</b> <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 x</b>		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 3</b> , 1957, to <b>May 21</b> , 1957, that I last saw the deceased alive on <b>May 21</b> , 1957, and that death occurred at <b>6:27 pm</b> M. from the causes and on the date stated above. <b>L. L. Packer</b> ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/24.57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Little ROSE HILL Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Near Clearspring, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>May 25, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. H. Bowser</b>	



BUREAU V. S.

MAY 28 1957

RECEIVED

05626

## CERTIFICATE OF DEATH

Dr Brewer

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b> c. LENGTH OF STAY IN 1b <b>3 Days</b>		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Big Pool</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash County Hospital</b>		d. STREET ADDRESS -----	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>HENRY</b> Last <b>MYERS</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 15 1880</b>
9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Big Pool Wash. Co Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Henry J. Myers</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Myers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Bessie Myers Big Pool Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chr. Bronchial Asthma</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Nov 15, 1956</b> to <b>May 5, 1957</b> , that I last saw the deceased alive on <b>May 5, 1957</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clear Spring Md</b> DATE SIGNED <b>5/6/57</b>			
ACTUAL SIGNATURE <b>David R Brewer</b> M.D.		PHYSICIAN'S NAME (Type) <b>David R Brewer</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/8/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Shenks town Wash. Co Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>May 9 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Charles H. Powers</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

MAY 13 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9

CERTIFICATE OF DEATH

Reg. Dist. No.

05635  
302

05627

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>63 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>29 Broadway</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
f. STREET ADDRESS <b>29 Broadway</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED First Middle Last <b>William Hamilton Needy</b>				4. DATE OF DEATH Month Day Year <b>May 8 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 25, 1877</b>	
9. AGE (In years last birthday) <b>80 yrs</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store-owner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Jewelry</b>		11. BIRTHPLACE (State or foreign country) <b>Broadfording Wash. Md.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Samuel Needy</b>				14. MOTHER'S MAIDEN NAME <b>Louise Hauer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>217-32-4526</b>		17. INFORMANT Address <b>W. H. Needy Hagerstown Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTED TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>May 7, 1957</b> to <b>May 8, 1957</b> , that I last saw the deceased alive on <b>May 8, 1957</b> , and that death occurred at <b>11:19 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Robert P. Conrad M.D. 137 W. Wash. Hagerstown, Md. 5-10-57</b>							
ACTUAL <b>Robert P. Conrad</b>				PHYSICIAN'S NAME (Type) <b>Robert P. Conrad 137 W. Washington St. Hagerstown Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>				ADDRESS <b>Hagerstown Md.</b>		24. REC'D BY REGISTRAR <b>May 13, 1957</b>	
24a. REGISTRAR'S SIGNATURE <b>Shirley Bowers</b>							

BUREAU V. B.

MAY 15 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05628

## CERTIFICATE OF DEATH

DR W. D. Campbell 05636

Reg. Dist. No 302

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>14 Yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>18 West Side Ave</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN HENRY NUSSEAR Sr</b>				4. DATE OF DEATH Month Day Year <b>May 16 1957 19</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>White</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>Jan 24 1871</b>	
9 AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car Foreman U.M.W.R. Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Emmitsburg Fred, Con</b>		11 BIRTHPLACE (State or foreign country) <b>Md.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Jesse H. Nussear</b>				14. MOTHER'S MAIDEN NAME <b>Mary C. Wierlok</b>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes; no, or unknown) <b>No</b>				16 SOCIAL SECURITY NO <b>705-10-4989</b>		17 INFORMANT <b>John H. Nussear Jr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Cardio-Vascular Disease</b> (c) <b>10 y. 4 m.</b>				19 West Side Ave Hagerstown Md. INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town)				20g (County)		20h (State)	
21. I certify that I attended the deceased from <b>Mar 5</b> , 19 <b>48</b> , to <b>May 16</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Feb 9</b> , 19 <b>57</b> , and that death occurred at <b>4 P</b> M. from the causes and on the date stated above							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <b>W. D. Campbell</b> M.D. <b>1457th Washington St</b>				<b>May 17 1957</b>			
PHYSICIAN'S NAME (Type) <b>W. D. Campbell, M.D.</b>				<b>Hagerstown Md</b>			
22a BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b DATE THEREOF <b>5/20/57</b>		22c NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a REC'D BY REGISTRAR <b>May 20 1957</b>	
						24b REG. STRAR'S SIGNATURE <b>Phyllis Bowers</b>	

BUREAU V. S.

MAY 23 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05637

05668

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Smithsburg</b>		c. LENGTH OF STAY IN 1b <b>52 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 S. Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lewis Edward Phenix</b>		4. DATE OF DEATH Month Day Year <b>May 22, 1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1888</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Beaver Creek, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Benjamin Phenix</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Sanders</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO <b>215-07-9080</b>	
17. INFORMANT <b>Hattie M. Phenix, Smithsburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular</b> DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 mo</b> <b>2 yrs</b> <b>5 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.0</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 15, 1956</b> to <b>May 22, 1957</b> , that I last saw the deceased alive on <b>May 22, 1957</b> , and that death occurred at <b>420.1</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Smithsburg, Md.</b> <b>5/22/57</b>			
ACTUAL SIGNATURE <b>George A. Kohler, M.D.</b>		M.D. <b>Smithsburg, Md.</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5-24-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Smithsburg, Md.</b>		ADDRESS <b>Smithsburg, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAY 24 57</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	



BUREAU V. S.

APR 24 1957

RECEIVED

05669

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>MD.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OF INSTITUTION <b>RFD #3</b>		d. STREET ADDRESS <b>1 RFD #3</b>	
3. NAME OF DECEASED (Type or print) First <b>Gladys</b> Middle <b>Ione</b> Last <b>Pike</b>		4. DATE OF DEATH Month <b>May</b> Day <b>28</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1897</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Augusta, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mortimoer Clipp</b>		14. MOTHER'S MAIDEN NAME <b>Lotte Mae Taylor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Ira W. Pike, Hagerstown Rd 3, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Fibrillation</b> <b>120.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>1 yr +</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 15, 1957</b> to <b>May 28, 1957</b> , that I last saw the deceased alive on <b>27 May 1957</b> , and that death occurred at <b>2:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>230 N. Potomac St., Hagerstown, Md.</b> DATE SIGNED <b>24 May 57</b> ACTUAL SIGNATURE <b>F F Lusby</b> M.D. PHYSICIAN'S NAME (Type) <b>Frank F. Lusby, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-31-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Smithsburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son, Hagerstown, Md.</b>		24. REC'D BY REGISTRAR <b>June 1, 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Shast R. Boevers</b>			

BUREAU Y. M.

JUN 4 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05629

## CERTIFICATE OF DEATH

05639

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington County Hospital</b>		d. STREET ADDRESS <b>26 W. Irvin Ave.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Frederick Berry Plummer</b>		4. DATE OF DEATH Month Day Year <b>May 25 19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religion</b>	
11. BIRTHPLACE (State or foreign country) <b>Bridgeport Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles W. Plummer</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Eakle</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>220-34-1032</b>	
17. INFORMANT <b>Mrs. Eva Price Hagerstown Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bone Sarcoma (Primary) 2" Lumbar Vertebra</b> <b>196x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pagets Disease of Bone - 3 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 Mar</b> , 19 <b>57</b> , to <b>25 May</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>24 May 57</b> , and that death occurred at <b>2:40 a M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F F Lusby</b>		ADDRESS (Street, city or town, state) M.D. <b>230 N Potomac</b> DATE SIGNED <b>27 May 57</b>	
PHYSICIAN'S NAME (Type) <b>Frank F. Lusby</b>		230 N. Potomac St. Hagerstown Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5-28-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Myersville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Scott F. Minnich &amp; Son</b>		ADDRESS <b>Hagerstown Md.</b>	
24a. REC'D BY REGISTRAR <b>May 28 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Cliff Howers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

RECEIVED

MAY 31 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05630

# CERTIFICATE OF DEATH

Reg. Dist. No.

05641

302

1. PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN 1b <b>2 WKS.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HAGERSTOWN</b>		d. STREET ADDRESS <b>RT. #2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WASHINGTON COUNTY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ESTHER</b> First Middle Last <b>RENNER</b>		4. DATE OF DEATH <b>MAY</b> Month Day <b>23</b> Year <b>19 57</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/21/1891</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EMANUEL GIFFIN</b>		14. MOTHER'S MAIDEN NAME <b>SARAH JOHNSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>MRS. VEDA SCHRIVER</b>		RT. #2 <b>HAGERSTOWN MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Asplenia</b> DUE TO (c) <b>Hypertensive Cardiovascular Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>1 yr.</b> <b>3 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>241X</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 3</b> , 19 <b>57</b> , to <b>May 23</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 23</b> , 19 <b>57</b> , and that death occurred at <b>11:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Philip J. Hirshman</b> M.D. <b>159 W. Washington St., Hagerstown, Md. 5/25/57</b>			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) <b>Philip J. Hirshman, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>5/27/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SAMPLES MANOR CHURCH</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Hermet, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>May 28 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>	

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MAY 31 1957

BUREAU V. E.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

VS. A15ME(S)  
SM 9/55

05631

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Dr. Wells 05642  
Reg. Dist. No. 302

1. PLACE OF DEATH COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wash. County Hospital</b>				d. STREET ADDRESS <b>2800 Quebec St N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>EVA</b> Last <b>RICE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>1</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>June 28 1906</b>		9. AGE (In years last birthday) <b>50</b> yrs.	
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Personelle Walter Reed Hospital</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Kan.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lewis C. Rice</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Hawkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-42-6792</b>		17. INFORMANT Address <b>Mrs Nellie R. Lakin 3014 Weldon Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> DUE TO <b>Open fracture lt. knee</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Closed fracture lt elbow and clavicle hemorrhage and shock</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident</b>					
20c. TIME OF INJURY Month, Day, Year <b>6:00 p.m. 4-28-1957</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Rural-Clearspring Wash Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>S. Robert Wells</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>S. Robert Wells, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/6/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Highland Cemetery Ottawa Franklin Co Kansas</b>		22d. LOCATION (City, town, or county) (State) <b>Wash Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>				24a. REC'D BY REGISTRAR <b>May 4 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frank Bowers</b>	

MEDICAL CERTIFICATE



RECEIVED

MAY 7 1957

BUREAU V. S.

05632

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>21 Yrs</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>268 Frederick St</b>						e. STREET ADDRESS <b>268 Frederick St</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>SYLVESTER BURTRAM RICKETT</b>		4. DATE OF DEATH Month <b>May</b> Day <b>7</b> Year <b>1957</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 7 1890</b>	
9. AGE (In years last birthday) <b>66</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>10</b> Hours <b>5</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Velder Potomac- Edison Garage</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Springfield Clark Co</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Rickett</b>						14. MOTHER'S MAIDEN NAME <b>Anna Banzhof</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-8066</b>		17. INFORMANT <b>Mrs Stella D. Rickett 268 Frederick St Hagerstown Md.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Arterio Sclerosis + Hypertension</b> DUE TO (c) <b>5 yrs</b>										INTERVAL BETWEEN ONSET AND DEATH <b>1 mo</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. 2.</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Hagerstown Md.</b>		20g. (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1</b> , 1957, to <b>7 May</b> , 1957, that I last saw the deceased alive on <b>5 May</b> , 1957, and that death occurred at <b>9:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>231 N. Columbia Hagerstown Md.</b> DATE SIGNED <b>7 May 57</b>											
ACTUAL SIGNATURE <b>F. F. Lusby</b>				PHYSICIAN'S NAME (Type) <b>F. F. Lusby</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md.</b>		22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>						24a. REC'D BY REGISTRAR <b>May 9 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

MAY 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05644

05670

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cavetown</u>		c. LENGTH OF STAY IN 1b <u>75 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Cavetown</u>	
3. NAME OF DECEASED (Type or print) First <u>Reuben</u> Middle <u>Daniel</u> Last <u>Ridenour</u>		4. DATE OF DEATH Month <u>May</u> Day <u>13</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 3, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <u>5</u> Days <u>17</u> Hours <u>11</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Smithsburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Ridenour</u>		14. MOTHER'S MAIDEN NAME <u>Susan Kline</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Earl D. Ridenour,</u>		Address <u>Cavetown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 1/2 yrs.</u> <u>10 yrs.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/30</u> , 19 <u>56</u> , to <u>5/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>3/17</u> , 19 <u>57</u> , and that death occurred at <u>3:00</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles F. Hess</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Smithsburg Md. 5/13/57</u>	
PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/16/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg</u>		22d. LOCATION (City, town, or county) (State) <u>Smithsburg, Washington Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Groves</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 14 57</u>	
ADDRESS <u>Waynesboro</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

BUREAU V. B.

1957

RECEIVED

05633

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. LENGTH OF STAY IN 1b <b>2 1/2 Yrs</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Washington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>219 Bryan Place</b>		e. STREET ADDRESS <b>219 Bryan Place</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>MADGE RAYETTA RIDGLEY</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1957</b>									
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug 21 1903</b>	9. AGE (In years last birthday) <b>53</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown Wash. Co Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Harry F. Rautzahn</b>				14. MOTHER'S MAIDEN NAME <b>Sarah E. Hamburg</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-09-3686</b>		17. INFORMANT <b>William E. Ridgley</b> Address <b>219 Bryan Pl.</b>							
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Tumor</b> <b>237X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>9 MOS.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Hagerstown</b>		(County) <b>Washington</b>		(State) <b>Md</b>	
21. I certify that I attended the deceased from <b>Aug. 10, 1956</b> , to <b>May 4, 1957</b> , that I last saw the deceased alive on <b>April 15, 1957</b> , and that death occurred on _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>119 N. Potomac Street Hagerstown, Maryland.</b> DATE SIGNED <b>May 6, 57</b>											
ACTUAL SIGNATURE <b>R. A. Bell</b>		M.D. <b>R. A. Bell</b>		ADDRESS <b>119 N. Potomac Street</b>		DATE SIGNED <b>May 6, 57</b>					
PHYSICIAN'S NAME (Type) <b>R. A. Bell</b>		<b>Hagerstown, Maryland.</b>									
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/7/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Hagerstown Wash. Co Md</b>		(State) <b>Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>		24a. REC'D BY REGISTRAR <b>May 9, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis H. Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

MAY 13 1957

RECEIVED

05671

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <b>Maryland</b> b COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Clearspring Md RFD #1</b>		c. LENGTH OF STAY IN 1b <b>70 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Dry Run</b>		e. STREET ADDRESS <b>1 Dry Run</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Jane</b> Last <b>Robinson</b>		4. DATE OF DEATH Month <b>May</b> Day <b>5</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 13 1886</b>
9. AGE (In years last birthday) <b>70 yrs</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>5</b> Days <b>21</b> Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (State or foreign country) <b>Clearspring Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John Faith</b>	
14. MOTHER'S MAIDEN NAME <b>Cornelia Slayman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. David Robinson</b> Address <b>Clearspring Md RFD #1</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>Arterial Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 year</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <b></b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Apr. 28, 1957</b> to <b>May 3, 1957</b> , that I last saw the deceased alive on <b>May 4, 1957</b> , and that death occurred at <b>9:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clear Spring Md</b> DATE SIGNED <b>5/6/57</b>			
ACTUAL SIGNATURE <b>David R. Brewer</b> M.D.			
PHYSICIAN'S NAME (Type) <b>David R. Brewer</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 8-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Pauls Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Clearspring Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. L. Wolf</b>		ADDRESS <b>Wilmington, Md</b>	24a. REC'D BY REGISTRAR <b>May 8-57</b>
24b. REGISTRAR'S SIGNATURE <b>Joseph W. Murray</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the General Director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

MAY 10 1957

BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
CERTIFICATE OF DEATH											
Reg. Dist. No. 05642 302											
1. PLACE OF DEATH a. COUNTY <b>Washington</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 Weeks</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. County Hospital</b>				d. STREET ADDRESS <b>Fahrney-Keedy Mem. Home</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>NETTIE</b> Middle <b>-----</b> Last <b>ROHRER</b>				4. DATE OF DEATH Month <b>May</b> Day <b>10</b> Year <b>1957</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 6 1860</b>		9. AGE (In years last birthday) <b>96</b> yrs.		10. IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min <b>---</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Md Hagerstown Wash. Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Elias Rohrer</b>				14. MOTHER'S MAIDEN NAME <b>Susan Miller</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Records Fahrney-Keedy Mem. Home Boonsboro Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fractured Hip -</b> DUE TO (c) <b>---</b> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs 5 days</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Confused &amp; senility - fell while walking from chair to bed</b>											
20c. TIME OF INJURY Month, Day, Year <b>6 p.m. May 5, 1957</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Fahrney-Keedy Home Boonsboro</b>		20f. (City or town) (County) (State) <b>Wash. Md.</b>			
21. I certify that I attended the deceased from <b>April 1, 1957</b> , to <b>May 10, 1957</b> , that I last saw the deceased alive on <b>May 9, 1957</b> , and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Boonsboro Md.</b> ACTUAL SIGNATURE <b>G. W. Hevan</b> M.D. <b>Boonsboro Md.</b> DATE SIGNED <b>5/11/57</b> PHYSICIAN'S NAME (Type) <b>G. W. Hevan</b> <b>mdr</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Hagerstown Wash. Co Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman Hagerstown Md.</b>						24a. REC'D BY REGISTRAR <b>May 16 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Phyllis H. Bowers</b>			

BUREAU V. 81

NOV 20 1957

RECEIVED

05635

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Wash. Co. Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Marie</b> Middle <b>Roberta</b> Last <b>Ruck</b>				4. DATE OF DEATH Month <b>5</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 5, 1928</b>	
9. AGE (In years last birthday) <b>29</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>			
11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Nathan J. Souders</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Zimmerman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>218-24-7519</b>			
17. INFORMANT <b>Vincent Ruck</b>				Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <b>Carcinoma of Mammary Gland metastatic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>1 Mo</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>4/29/57</b> to <b>5/3/57</b> , that I last saw the deceased alive on <b>3/31/57</b> , and that death occurred at <b>1077</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>William J. Fackler</b> <b>5/3/57</b>							
ACTUAL SIGNATURE <b>William J. Fackler</b>				M. D. <b>William J. Fackler</b>			
PHYSICIAN'S NAME (Type) <b>William J. Fackler</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>June 2, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>				ADDRESS <b>Hagerstown, Md.</b>			
24a. REC'D BY REGISTRAR <b>June 3, 1957</b>				24b. REGISTRAR'S SIGNATURE <b>Frank H. Powers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
JUN 12 1957  
BUREAU V. S.

05636

CERTIFICATE OF DEATH

05648

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>			
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Washington Co. Hospital</b>				d. STREET ADDRESS <b>425 McDowell Ave.,</b>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>J</b> Last <b>Ruth</b>				4. DATE OF DEATH Month <b>5</b> Day <b>14</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1888</b>		9. AGE (In years last birthday) <b>69</b> yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild Aircraft</b>		11. BIRTHPLACE (State or foreign country) <b>Washington Co.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Ruth</b>				14. MOTHER'S MAIDEN NAME <b>Mary C. Eichelberger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-10-2675</b>		17. INFORMANT <b>Mrs. Lillian Ruth</b> Address <b>Hagerstown, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>411X Congestive Heart Failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Calcific aortic stenosis (rheumatic)</b> DUE TO (c) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>154 West Washington St.,</b>	
20f. (City or town) (County) (State) <b>Hagerstown Md.</b>							
21. I certify that I attended the deceased from <b>5/3, 1940</b> , to <b>5/14, 1957</b> , that I last saw the deceased alive on <b>5/13, 1957</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hagerstown, Md.</b> DATE SIGNED <b>5:15:57</b>							
SIGNATURE <b>John H. Hornbaker</b> M.D.							
PHYSICIAN'S NAME (Type) <b>John H. Hornbaker, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-16-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b> ADDRESS <b>Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>May 17, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. B. B. B.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 4

MAY 20 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown R 4</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X1 Hagerstown Route 4</b>	
		f. STREET ADDRESS	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Clayton</b> Last <b>Sauders</b>		4. DATE OF DEATH Month <b>5</b> Day <b>21</b> Year <b>1957</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 23, 1870</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired organ builder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mallers</b>	
11. BIRTHPLACE (State or foreign country) <b>Wash. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel Sauders</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-10-3428</b>	
17. INFORMANT <b>Carl O. Sheppard</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Generalized Arterio Sclerosis with</b> <b>450.0</b> DUE TO <b>myocardial failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>16 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 1945</b> to <b>21 May 1957</b> , that I last saw the deceased alive on <b>19 May 1957</b> , and that death occurred at <b>9:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F F Lusby</b>		DATE SIGNED <b>21 May 57</b>	
PHYSICIAN'S NAME (Type) <b>F F Lusby</b>		ADDRESS (Street, city or town, state) <b>230 W. Prima Hagerstown Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>5-23-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24. REC'D BY REGISTRAR <b>May 24 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Frank H. Severs</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

MAY 27 1957

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05637

## CERTIFICATE OF DEATH

05650

Reg. Dist. No. 302

1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>432 N. Muller St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <u>John Carter Shue</u>				4. DATE OF DEATH <u>May 29, 1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28, 1957</u>	
9. AGE (In years, last birthday) <u>1</u> yrs		10. IF UNDER 1 YEAR, Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min <u>1</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
13. FATHER'S NAME <u>Lloyd Bruce Shue</u>				14. MOTHER'S MAIDEN NAME <u>Muriel Gladys Hansen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name and rank) <u>No.</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Lloyd B. Shue</u>				Address <u>Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Albericans (Hyaline membrane)</u>							<u>24 hrs</u>
762.5 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Prematurity</u>							<u>24 hrs</u>
(c)							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5:28</u> , 1957, to <u>5:29</u> , 1957, that I last saw the deceased alive on <u>5:29</u> , 1957, and that death occurred at <u>10 A</u> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>E. Margaret Sullivan</u>				DATE SIGNED <u>5-29-57</u>			
PHYSICIAN'S NAME (Type) <u>E. MARGARET SULLIVAN, M.D.</u>				ADDRESS (Street, city or town, state) <u>314 N. Pennacott</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>5/30/57</u>		<u>Rest Haven Cem</u>		<u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Horne</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>May 31, 1957</u>	
						24b. REGISTRAR'S SIGNATURE <u>Chas H Bowers</u>	

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RECEIVED  
JUN 3 1957  
BUREAU V. I.

05673

## CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a COUNTY <b>Washington</b> <b>MARYLAND</b>				2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b STATE <b>No Carolina</b> c COUNTY <b>Rowan</b>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Williamsport</b>				c LENGTH OF STAY IN 1b <b>1 Week</b>			
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Williamsport Sanatorium</b>				d STREET ADDRESS <b>2111 West Innes St</b>			
3 NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>MARY</b> Last <b>SLAGEN</b>				4 DATE OF DEATH Month <b>May</b> Day <b>25</b> Year <b>1957</b>			
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>Oct 1 1871</b>	9 AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>2</b> Hours <b>0</b> Min <b>0</b>	IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife Own Home</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>Taneytown York Co Pa</b>				11 BIRTHPLACE (State or foreign country) <b>USA</b>			
13. FATHER'S NAME <b>John Bair</b>				14 MOTHER'S MAIDEN NAME <b>Charlotte Green</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service) <b>-----</b>				16 SOCIAL SECURITY NO. <b>None</b>			
17 INFORMANT <b>Howard E. Slagen</b>				Address <b>2111 W. Innes St</b>			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Stasis type.</b> DUE TO <b>Salisbury No Car.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic obstructive heart disease</b> DUE TO <b>2 days.</b> (c) <b>2 months.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>22 May 1957</b> to <b>25 May 1957</b> that I last saw the deceased alive on <b>24 May 1957</b> , and that death occurred at <b>2:10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>58 W. Patoma Street</b> DATE SIGNED <b>27 May 57</b> ACTUAL SIGNATURE <b>Paul Hank</b> M.D. <b>Williamsport, Md.</b> PHYSICIAN'S NAME (Type) <b>PAUL HANK, M.D.</b>							
22a BURIAL, CREMATION, REMOVAL (Specify)		22b DATE THEREOF		22c NAME OF CEMETERY OR CREMATORY		22d LOCATION (City, town or county) (State)	
<b>Burial</b>		<b>5/27/57</b>		<b>Mt Carmel Cemetery</b>		<b>Littlestown Adams Co Pa</b>	
23 FUNERAL DIRECTOR'S SIGNATURE <b>Andrew K. Coffman</b>				ADDRESS <b>Hagerstown Md.</b>			
24a REC'D BY REGISTRAR <b>June 3-57</b>				24b REGISTRAR'S SIGNATURE <b>E. M. McElroy</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 5 1957

RECEIVED

05674

## CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING</u>				c. LENGTH OF STAY IN 1b <u>20 YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ST. JOHN'S</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLEAR SPRING</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIOLA</u> <u>B.</u> <u>SNYDER</u>				4. DATE OF DEATH Month Day Year <u>5</u> <u>17</u> <u>19 57</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 12 1907</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WILLIAM B. SNYDER</u>				14. MOTHER'S MAIDEN NAME <u>ANNA E. GROSH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>10-3</u>		17. INFORMANT <u>GROSH, A. S.</u>		Address <u>1111 11th St., N.W.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION ACUTE WITH MYOCARDIAL INFARCTION</u> <u>440.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>ATHEROSCLEROSIS</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u>  <u>UNKNOWN</u>  <u>UNKNOWN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB 4</u> , 19 <u>57</u> , to <u>MAY 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>MAY 16</u> , 19 <u>57</u> , and that death occurred at <u>9:45 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Archie Robert Cohen</u> M.D.				PHYSICIAN'S NAME (Type) <u>ARCHIE ROBERT COHEN, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/20/57</u>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>ST. PETER'S CATHEDRAL</u>	
22d. LOCATION (City, town, or county) (State) <u>CLEAR SPRING WASH. CO. MD.</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Clark</u> ADDRESS <u>Clear Spring, Md</u>			
24a. REC'D BY REGISTRAR <u>May 21 57</u>				24b. REGISTRAR'S SIGNATURE <u>Joseph W. Murphy</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death Page 4

may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 81

NOV 3 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05653

05638

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>30 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington County Hospital</b>				d. STREET ADDRESS <b>339 Elizabeth Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>HATTIE</b> <b>VIOLA</b> <b>SQUIBB</b>				4. DATE OF DEATH Month <b>May</b> Day <b>2</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 18, 1885</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b>57</b>	IF UNDER 24 HRS Hours <b>57</b> Min <b>57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Mechanicsburg, Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>Frank W. Gelwicks</b>				14. MOTHER'S MAIDEN NAME <b>Harriett V. Neff</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Margaret Redmond</b> Address <b>9 Madison Ave. Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia, cause unknown</b>							<b>1 month</b>
DUE TO <b>053.4</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <b>904.9</b>							
(b) <b>Undernutrition</b>							<b>3-4 months</b>
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis, Fracture left humerus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>16 Mar. 1957</b> to <b>26 April 1957</b> , that I last saw the deceased alive on <b>26 April 1957</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard T. Binford</b>				M.D. <b>1135 POTOMAC AVENUE</b>		DATE SIGNED <b>4 MAY 57</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M.D.</b>				HAGERSTOWN, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 4, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mechanicsburg Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mechanicsburg Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				ADDRESS <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR <b>May 4, 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wm. C. Frost via Rec.</b>			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. A.

MAY 7 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05639

## CERTIFICATE OF DEATH

05654

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>				c. LENGTH OF STAY IN 1b <b>5 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1531 Dual Highway Hag. Md.</b>				e. STREET ADDRESS <b>1531 Dual Highway Hagerstown</b>			
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>Cocoran</b> Last <b>Steffey</b>				4. DATE OF DEATH Month <b>May</b> Day <b>29</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1884</b>	9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months <b>10</b> Days <b>21</b> Hours <b></b> Min <b></b>	IF UNDER 24 HRS Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd Chief Clerk Hillman Coal &amp; Coke Co.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>U. S. A</b>	
13. FATHER'S NAME <b>Mc Kendrick Steffey</b>				14. MOTHER'S MAIDEN NAME <b>Rose Sheets</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>				16. SOCIAL SECURITY NO. <b>192-10-6338</b>			
17. INFORMANT <b>Mrs. Blanche Steffey</b>				Address <b>1531 Dual Highway Hagerstown Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.0</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> (c) <b></b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Rheumatic heart disease with multiple valvular defects.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>2 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>416x</b>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b></b>			
20c. TIME OF INJURY Month, Day, Year Hour <b></b> o. m. <b>19</b> p. m. <b></b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	
20f. (City or town) <b></b>				20g. (County) <b></b>		20h. (State) <b></b>	
21. I certify that I attended the deceased from <b>Feb. 25</b> , 19 <b>55</b> to <b>May 29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>May 6</b> , 19 <b>57</b> , and that death occurred at <b>11:45 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>107 Professional Arts Bldg.,</b> DATE SIGNED <b></b>							
ACTUAL SIGNATURE <b>W. T. Layman</b>				M.D. <b>107 Professional Arts Bldg.,</b>			
PHYSICIAN'S NAME (Type) <b>William T. Layman, M.D., Hagerstown, Maryland.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 1 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Williamsport Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. T. Layman</b>				24a. REC'D BY REGISTRAR <b>May 31 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Blanche Bowers</b>	

BUREAU V. 3

JUN 3 1957

RECEIVED

05640

CERTIFICATE OF DEATH

Reg. Dist. No. 3021

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Franklin</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u>			
c. LENGTH OF STAY IN 1b <u>2 yrs</u>				d. STREET ADDRESS <u>16 South Carlisle st</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Conv Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Susan</u> Middle <u>Jane</u> Last <u>Summers</u>				4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/15/1881</u> 76 yrs.	
9. AGE (In years last birthday) <u>76</u>		IF UNDER 1 YEAR Months <u>11</u> Days <u>15</u> Hours <u>15</u> Min <u>00</u>		IF UNDER 24 HRS. Hours <u>15</u> Min <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Housekeeping</u>		11. BIRTHPLACE (State or foreign country) <u>Franklin Co Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>George Gossard</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Rummel</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>Mrs. Earl Summers, Greencastle Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular disease</u> 6 yrs. <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Apoplexy</u> 3 yrs. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>34X</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a. 11</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>June</u> , 19 <u>54</u> , to <u>May 31</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>5/30</u> , 19 <u>57</u> , and that death occurred at _____ M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David R. Hess</u> M.D.				ADDRESS (Street, city or town, state) <u>Shady Grove Pa</u> DATE SIGNED <u>6/1/57</u>			
PHYSICIAN'S NAME (Type) <u>David R. Hess, M. D.</u>				<u>Shady Grove, Pa.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/3/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rauffmans Station Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Antietam Twp Franklin Co Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Franklin H. Zimmerman</u> ADDRESS <u>Greencastle, Pa.</u>				24. REC'D BY REGISTRAR <u>June 3, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles H. Bowers</u>	

RECEIVED  
UN 12 1957  
BUREAU V. S.

05641

## CERTIFICATE OF DEATH

Reg. Dist. No.

05655  
302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Wash.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Washington Co. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Glendera</b> Middle <b>Edna</b> Last <b>Swope</b>		4. DATE OF DEATH Month <b>5</b> Day <b>6</b> Year <b>19 57</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 26, 1881</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>19</b> Hours <b>57</b>	11. IF UNDER 24 HRS Months <b>7</b> Days <b>19</b> Hours <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hag. Mfg. Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Wm. Swope</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Allison</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-09-8238</b>	
17. INFORMANT <b>John E. Swope</b>		Address <b>Hagerstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>anterosclerotic myocardial heart disease</b> DUE TO <b>myocardial failure grade IV</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>myocardial failure grade IV</b> (c) <b>myocardial failure grade IV</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>None</b>	
20c. TIME OF INJURY Month <b>None</b> Day <b>19</b> Year <b>19 57</b> Hour <b>None</b> a. m. <b>None</b> p. m. <b>None</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	20f. (City or town) <b>None</b> (County) <b>None</b> (State) <b>None</b>
21. I certify that I attended the deceased from <b>April 15, 19 57</b> , to <b>May 6, 19 57</b> , that I last saw the deceased alive on <b>May 6, 19 57</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. Robert Wells</b>		ADDRESS (Street, city or town, state) <b>115 N. Potomac Street</b>	
PHYSICIAN'S NAME (Type) <b>S. Robert Wells, M.D.</b>		DATE SIGNED <b>5-6-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>5-9-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill</b>		22d. LOCATION (City, town, or county) <b>Hagerstown</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fred W. Kraiss</b>		ADDRESS <b>Hagerstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>May 8, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Bowers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. M.

MAY 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

05675

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05656

Reg. Dist. No. 55

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washin ton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural -Boonsboro		c. LENGTH OF STAY IN 1b 1 hr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X2 Ringgold	
3. NAME OF DECEASED (Type or print) First Middle Last Clair - Thor son		4. DATE OF DEATH Month Day Year May 11 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 8, 1902
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Moller's	
11. BIRTHPLACE (State or foreign country) Waynesboro, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Motter Thompson		14. MOTHER'S MAIDEN NAME Susan Hehn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 173-03-1387	
17. INFORMANT Address Mrs. Claire Thompson- R # 5 Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) arteriosclerotic coronary heart disease (c) DUE TO (a), stating the underlying cause last. 1 yr PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-14-57	
22c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery		22d. LOCATION (City, town, or county) (State) Waynesboro, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Walter Y. Stove, Waynesboro, Pa.		24a. REC'D BY REGISTRAR DATE 5/10/57	
		24b. REGISTRAR'S SIGNATURE Sam Lust	



BUREAU V. S.

MAY 15 1957

RECEIVED

05642

CERTIFICATE OF DEATH

Reg. Dist. No. 302

05657

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WAS HINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
c. LENGTH OF STAY IN 1b 30 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 103 BELVIEW AVE.		d. STREET ADDRESS 103 BELVIEW AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ANNA MARIE TOMS		4. DATE OF DEATH Month Day Year MAY 27 19 57	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH 12/25/1900
9. AGE (In years last birthday) 56 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11 BIRTHPLACE (State or foreign country) IOWA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BEN JAMIN DORTY		14 MOTHER'S MAIDEN NAME SARAH CLEVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16 SOCIAL SECURITY NO. none	
17. INFORMANT Address LAWRENCE L. TOMS, HAGERSTOWN, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 583x DUE TO Cardiac collapse (b) Cystic Liver (c) Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last INTERVAL BETWEEN ONSET AND DEATH Min yr.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 422.1			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 1952, to May 27 1957, that I last saw the deceased alive on May 26 1957, and that death occurred at 3 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Louis E. Graff M.D. 119 E. Antietam St Hagerstown, Md. 5/28/57 PHYSICIAN'S NAME (Type) Louis E. GRAFF M.D. Hagerstown, Md.			
22a BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b DATE THEREOF 5/29/57	22c NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY	22d LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23 FUNERAL DIRECTOR'S SIGNATURE W. J. Hornum, Hagerstown, Md.		24a REC'D BY REGISTRAR DATE May 31, 1957	24b REGISTRAR'S SIGNATURE Phas H. Bowers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED  
N 3 1957  
BUREAU V. S.

05643

## CERTIFICATE OF DEATH

05658

Reg. Dist. No.

202

1 PLACE OF DEATH a. COUNTY <b>WASHINGTON</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HAGERSTOWN</b>		c. LENGTH OF STAY IN IT <b>ONE YEAR</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARLOCK NURSING HOME</b>		e. STREET ADDRESS <b>BOONSBORO MD. R.I.</b>	
3. NAME OF DECEASED (Type or print) <b>ANNIE LYDIA CATHERINE TOMS</b>		4. DATE OF DEATH Month Day Year <b>MAY 15 1957 19</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>MAY 2 1872</b>
9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>MYERSVILLE FRED. CO. MD. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE W. WACHTELL</b>		14. MOTHER'S MAIDEN NAME <b>LOUISA METZGER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>NONE</b>	
17. INFORMANT <b>HUBERT W. TOMS BOONSBORO MD R.I.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arterio-sclerosis</b> DUE TO (c) <b>3 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>450.0</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 8, 1957</b> , to <b>May 15, 1957</b> , that I last saw the deceased alive on <b>May 14, 1957</b> , and that death occurred at <b>10 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 S. Main St., Boonsboro, Md.</b> DATE SIGNED SIGNATURE <b>J. Hubert Wade</b> PHYSICIAN'S NAME (Type) <b>J. Hubert Wade, M. D.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>ENTOMBMENT</b>		22b. DATE THEREOF <b>MAY 17 57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BOONSBORO MAUSOLEUM</b>		22d. LOCATION (City, town, or county) (State) <b>BOONSBORO WASH. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bart Funeral Home Boonsboro Md</b>		24. REC'D BY REGISTRAR <b>May 20 1957</b>	
24a. REGISTRAR'S SIGNATURE <b>Phyllis Bowers</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 23 1957

RECEIVED

05644

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

05659

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>17 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				e. STREET ADDRESS <u>811 The Terrace</u>			
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>M.</u> Last <u>Tooma</u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 14, 1887</u>	
9. AGE (In years last birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months <u>70</u> Days <u>4</u> Hours <u>8</u> Min.		11. BIRTHPLACE (State or foreign country) <u>Zahle, Lebanon</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Partner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oriental Rugs</u>			
13. FATHER'S NAME <u>Wilhelm Tooma</u>				14. MOTHER'S MAIDEN NAME <u>Mary Maloof</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>211-34-0890</u>			
17. INFORMANT <u>Mrs. Sam. M. Tooma, Hagerstown, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO (b) <u>Arterio-sclerotic heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs</u> <u>3 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 1957</u> to <u>May 22, 1957</u> , that I last saw the deceased alive on <u>May 22, 1957</u> , and that death occurred at <u>11:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>F. F. Lusby</u>				DATE SIGNED <u>24 May 57</u>			
PHYSICIAN'S NAME (Type) <u>F. F. Lusby</u>				ADDRESS (Street, city or town, state) <u>230 N. Potomac Hagerstown Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-25-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Rouser</u>				24. REGISTRAR'S SIGNATURE <u>Walter Rouser</u>			
ADDRESS <u>300 N. Potomac St.</u>				DATE REC'D BY REGISTRAR <u>May 25, 1957</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

MAY 28 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

45660

05645

Item 14 Md. J-16 C-13-57 es

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>6 HRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Smithsburg - Rural</u>		d. STREET ADDRESS <u>'Smithsburg Md. R. 2.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>C.</u> Last <u>Waltz</u>				4. DATE OF DEATH Month <u>May</u> Day <u>31</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug-9-1894</u>	9. AGE (in years last birthday) <u>63-9-22</u>	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Co. Road Dept.</u>		11. BIRTHPLACE (State or foreign country) <u>Wash. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Waltz</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>				16. SOCIAL SECURITY NO. <u>217-10-3459</u>		17. INFORMANT <u>Harold Lee Waltz</u>	
				Address <u>Smithsburg Md. R. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>6 hrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> o. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. F. W. D. [Signature]</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June-2-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Boonsboro Wash. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>East Funeral Home Boonsboro Md</u>				24a. REC'D BY REGISTRAR <u>June 5, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

JUN 7 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Form PM-3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
3M 9/55

05646

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05661

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washin ton			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 22 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) at home 59 Blooms Alley				d. STREET ADDRESS 59 Blooms Alley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Harvey Last Ware				4. DATE OF DEATH Month May Day 1 Year 19 57			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 21, 1904	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Connellsville, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gilbert Ware				14. MOTHER'S MAIDEN NAME Carrie Taylor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year, or dates of service) World War 2		17. INFORMANT Mrs. Jessie Manuel -Sister		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of liver 581.1 DUE TO Generalized rheumstoid arthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1220 DUE TO (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-4-1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md				24. REC'D BY REGISTRAR May 4, 1957		24b. REGISTRAR'S SIGNATURE E. H. Bowers	

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RECEIVED

MAY 7 1957

BUREAU V. S.

## CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wagerstown, Md.</u>		c. LENGTH OF STAY IN 1b <u>32 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wagerstown, Maryland</u>	
f. STREET ADDRESS <u>43 W. Bethel Street.</u>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Richard</u> Last <u>Watson</u>		4. DATE OF DEATH Month <u>5</u> Day <u>3</u> Year <u>19 57</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> Hours <u>57</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pullman Porter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Carmichael, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Watson</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Steward</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>160 Professional Ants. bldg.</u>	
17. INFORMANT <u>Mrs Nettie E. Watson</u>		Address <u>43 W. Bethel St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>334X None</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 20</u> , 19 <u>57</u> , to <u>May 3</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>May 2</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>William T. Layman</u> M.D. <u>160 Professional Ants. bldg.</u>		<u>5-4-57</u>	
PHYSICIAN'S NAME (Type) <u>William T. Layman, M.D.</u>		<u>Wagerstown Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-6-1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Wagerstown Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Rawson, reg. M.D.</u>		ADDRESS <u>May 6, 1957</u> <u>East Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 8 1901

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05648

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05663

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown Md.</b>		c. LENGTH OF STAY IN 1b <b>3 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington County Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sharpsburg Md.</b>	
f. STREET ADDRESS <b>1 Sharpsburg Md.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Roosevelt</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>May</b> Day <b>4</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1910</b>
9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months <b>18</b> Days <b>18</b> Hours <b>18</b> Min.	11. IF UNDER 24 HRS. Hours <b>18</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assembly</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fairchild's Aircraft Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-30-9465</b>	
17. INFORMANT (son) <b>Paul E. Williams</b>		Address <b>Keedysville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>816X</b> DUE TO <b>Fractured skull(closed)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>hemorrhage &amp; shock</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3:45 PM</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in auto collision Route 65, 1/2 Mile N.. of Tilghmaton, Md.</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>1A</b> o. m. <b>May 4</b> 19 <b>57</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt 65</b>	20f. (City or town) (County) (State) <b>Hagerstown Wash. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>S. Robert Welle</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>S. Robert Welle, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>May 5 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>May 6-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bakersville Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Bakersville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edw. J. Lee</b>		ADDRESS <b>222 W. Williamsport, Md.</b>	
24a. REC'D BY REGISTRAR <b>May 5, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Bowers</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY 11  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAY 7 1957  
BUREAU V. 8

05678

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Boonsboro</b>				c. LENGTH OF STAY IN 1b <b>5 mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cascade</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Nalley's Nursing Home</b>				d. STREET ADDRESS <b>S. Main St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALBERT J WRIGHT</b>				4. DATE OF DEATH Month <b>May</b> Day <b>23</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 26, 1874</b>		9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Calhoun Co. W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William Wright</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Mrs. Obed Bailey <b>Middletown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
			20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <b>April 1, 1957</b> to <b>May 23, 1957</b> , that I last saw the deceased alive on <b>May 22, 1957</b> , and that death occurred at <b>5 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>G. W. Levan</b> M.D.				ADDRESS (Street, city or town, state) <b>Boonsboro,</b> DATE SIGNED <b>5/24/57</b>			
PHYSICIAN'S NAME (Type) <b>G. W. Levan</b> (G. W. Levan) <b>Boonsboro, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 26, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rest Haven Funeral Chapel Inc. Hagerstown, Md.</b>				24a. REC'D BY REGISTRAR <b>May 23 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. G. Horst &amp; Co.</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached to the certificate and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BUREAU V. 31

MAY 27 1957

RECEIVED